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Hysteria

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HYSTERIA

By

Louis A. Azorin

A THESIS

Presented to the Faculty of
The University of Nebraska College of Medicine
in Partial Fulfillment of Requirements for the
Degree of Doctor of Medicine

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INTRODUCTION

The purpose of this thesis is merely to present a cross section of a highly fascinating subject as represented by the literature. It has not been my endeavor to present my own ideas, although the vast amount of contradictory material which I read highly stimulated such a feeling. The reader will no doubt be imbued at times with a feeling of vagueness. This I attribute to the great number of theoretical conceptions proffered throughout the thesis. In addition, the very nature of the subject adds to this attitude. Even the doctors decry that psychiatry is not a true science. As yet, that statement is appallingly correct, but, little by little we are establishing scales in the field of human behavior and our treatment consequently loses much of its former empiricism. It is hoped that in the near future instruments of percision will be ours with which to accurately measure and record psychological reactions or thought - a procedure which at the present seems slightly ridiculous if not altogether impossible.

No attempt has been made to go into very much detail. Should the ambitious reader care to do so, however, the bibliography is at his disposal. The scope of my effort has been to present the outstanding points of a very broad subject, and if the reader gets the same impression after reading this thesis, my aim will not have been amiss.

DEFINITION

To define as protean a disease as hysteria and leave the reader with a clear concept of its intricate make-up, is indeed a difficult task. This difficulty may best be met by presenting the definitions formulated by some prominent men in this field. Hysteria is a psychoneuroses or so-called functional nervous disease which, tending to develop particularly in those predisposed by neuropathic heredity and by vicious environment, is dependent upon disintegration of personality and is characterized by symptoms originating from the morbid control of the body by subconscious states; whose symptoms can be shown to be but exaggerations or perversions of normal modes of feeling, of thinking, and of acting - a disease which is distinguished by a peculiar type of temperament, faulty adaptability to environment, pathologic increase in suggestibility resulting in the liability to develop many kinds of phenomena, and the possibility of the appearance of any one or more of a vast number of accidents arising from morbid ideation. (47)

Strecker-Ebaugh in discussing the war neuroses have this definition for hysteria:

A psychological situation which is unresolved becomes converted into certain phenomena which may be discovered objectively and which constitute the hysteria syndrome. We purposely refrain from discussing the nature of the situation, whether or not it need fulfill the Freudian requirements to produce hysteria - the exact mechanism by which the conversion

is accomplished; the role of suggestion and of physical factors. Broadly, hysteria was a more or less unconscious effort to escape from an intolerable situation and that "escape" was accomplished by a mechanism which showed as its end result certain objective disabilities which as long as they endured made impossible a return back to the intolerable situation. (Deprivation of hearing after listening to the cries and groans of the wounded; of sight after witnessing gruesome horrors, of smell after being detailed on burial parties, etc.) Always a psychological difficulty or conflict and that this was translated by a series of steps (psychologic, somatic or combined) in hysterical symptoms designed to protect the individual and indeed, to remove the very possibility of the recognition of the real difficulty. (43)

IMPORTANCE

Although I shall attempt to stress the importance of the psychoneuroses, and hysteria is but an example of the whole group, only the social and economic phases will be considered at this time.

To write that only 1.7% of mental disease is statistically included under the Psychoneuroses and from this percentage to draw the inference that less than 2,000 individuals become mentally disordered each year because of their influence, can give the student only a very misleading

conception of the magnitude of this problem. In reality the neuroses constitute the most frequent pathological situations encountered by the neuro-psychiatrist. Their frequency is not reflected in statistics, since neurotic patients, although they make up the bulk of the clientele of neurologist and psychiatrist, both in private and in out-patient practice, nevertheless rarely seek treatment in public mental hospitals. In fact, it is only the occasional patient whose neurosis becomes so severe and so complicated that he is judged mentally abnormal according to strict clinical standards. The student should view the problem in the light of its tremendous social significance. Even the mildest cases show in some instance an appreciable diminution of personal efficiency. If it could be reckoned, it would probably be found that the sum total of economic and social liabilities produced by the neuroses would be greater than the amount of damage inflicted on society by the psychoses. Therefore, the student can scarcely afford to neglect this aspect of neuro-psychiatry. (43)

Probably one of the most frequent problems which arises in the field of psychiatry is a question of differentiation between a neurosis and a psychosis. The following few paragraphs will help, it is hoped, to make the understanding of such difficulties more concise.

DIFFERENTIATION FROM PSYCHOSES

The psychoneuroses occupy a special place in the domain of psychological medicine. There are no clearly defined boundaries in nature and there is many a case of mental illness which it is difficult to assign definitely to the psychoneurotic or psychotic group. But between a well developed psychoses on the one hand and a full fledged psychoneuroses on the other, there is a world of difference, from the descriptive as well as from the therapeutic.

The distinctions between psychoneuroses in general and psychoses are symptomatic, psychopathological and therapeutic. The symptoms of the psychoneuroses will be enumerated later when the divergences from the clinical pictures presented by the psychoses will be evident. Considered biologically, that is, regarded as types of reaction to environment, the psychoneuroses are distinctive in several ways. A psychosis involves a change in the whole personality of the subject in whom it appears, while in the psychoneuroses it is only a part of the personality that is affected. With the development of a psychoneurosis there is often no outward change of personality of any kind. As Mayer puts it, a psychoneuroses is a part-reaction, while a psychoses is a total one. Furthermore, in a psychosis reality is changed qualitatively and comes to be regarded in a way very different from the normal, and

-the patient behaves accordingly; in the psychoneurosis reality remains unchanged qualitatively although its value may be quantitatively altered (diminished). But the psychoneurotic acts always as if reality had the same kind of meaning for him as the rest of the community. Psychopathologically the psychotic change in reality values is partly expressed as projection which consists in attributing an experience in origin entirely subjective to some external personal agency, e.g. an externally unfounded belief that one is being continually watched often depends on a sense of guilt, subjective but unconscious. Projection of this sort does not occur in the psychoneuroses.

Language is the symbolising function and the latest developed function for social adaptation. In the psychoneuroses language as such is never disturbed, whereas in the psychoses it often undergoes distortion. From the psychoanalytic view point, the unconscious comes to direct verbal expression in the psychoses; whereas in the psychoneuroses it never attains more than symbolic expression in some physical or localized mental disturbance. The reactions in the psychoses are of a much more primitive type on the whole than in the psychoneuroses, there is often a regression (so called) to an infantile level of activity in the psychotic. For example, wetting and soiling without shame are not found in psychoneurotics in the presence of clear consciousness.

Clinically, a psychoneuroses implies either a bodily

disturbance without structural lesion, and dependent in a way unknown to the patient on mental causes or a mental disturbance, not the result of bodily disease, in the form usually of morbid fears or more rarely of persistent ideas or motor acts, all of which the patient realises to be abnormal and the meaning of which he is at a loss to understand. The bodily disturbances may be sensory and entirely subjective, or motor and therefore directly observable. The sensory disturbances may occur in any or all of the systems of the body in a given patient - anesthesias, hyperesthesias and paresthesias, including pains, headaches, palpitations, breathlessness, anorexia, weakness and fatigue. These disturbances are emphatically real and not "imaginary". A hysterical pain is a real pain. The motor signs are paralysis, paresis, tics, tremors, postural deformities, anomalies of gait and speech (not language) disorders such as aphonia. The visceral disturbances include tachycardia, vomiting, diarrhea, constipation, polyuria, sweating and vasomotor disturbances generally. The mental disturbances appear as fears of all kinds, e.g. of heights, of sounds, of open spaces and especially of bodily illnesses, as localised losses of memory (islands of amnesia); as trance states and somnambulisms, as troublesome thoughts, usually with an uncomfortable feeling attached to them, such as anxiety, or as acts which the patient feels compelled to do. (53)

Dr. L. D. Lewis in differentiating the psychoneuroses

from the psychoses refuses to recognize any clear lines between them, but also admits the existence of a large group of men who hold to the contrary - i.e. that a definite distinction does exist between these groups and that in a fundamental way one never precedes or develops into the other. He also stresses the fact that the terms psychoneuroses and psychoses do not have a constant meaning to many psychiatrists. Consequently, they often use the terms interchangeably and thus tend to confuse one. His views are stated in the following lines.

The basis for argument that there are fundamental differences between the neuroses and psychoses depends chiefly upon matters revealed by the psychoanalytic technique. These observers hold that repression is a more involved matter than mere quantity and that it takes place to basic organized fixation points in the development, which fixation points differ in the psychoses from those found in the neuroses and that the neurosis is a difficulty between the instinctive drives and the super ego, while the psychosis is in the realm of the ego and ideal of the ego. In schizophrenia there is a destruction of the ideal of the ego which is also true of the paranoid subgroup, thus constituting a disease of the id. In the manic-depressive psychosis the relationship between the ego and the ideal ego is changed, while the organic detriments are diseases of the ego construction. Thus, the mechanisms in the psychosis are different from those in the anxiety neurosis, where the regression is to the edipus relationships or in the

compulsion obsessional neurosis where the regression is to the homosexual anal level and are thus never quite so deeply seated as in the so called narcissistic neuroses or psychoses where the regression goes to a deeply infantile level, or even beyond this into the earliest somatic components.

In the neurosis the instinctive drives are not acceptable to the super-ego and thus may become dissociated, while in the psychosis there is a definite dissociation with projection of the elements into the outside world. It is of some importance to recognize the fact that all those who are working intensely in psychoanalysis agree that there are fundamental differences between the neuroses and psychoses and these differences depend upon different sets or groups of integrated factors.

The psychoneurotic individual is one in whom the repressions have failed in part to the extent that the early instinctive tendencies (reproductive and destructive) are released or maintained in an unsuitable state which is not accepted by the ego as part of its own structure and thus a conflict is created between the ego and the id to the extent that the individual is perpetually or periodically in an uncomfortable state of mind at the emotional level. The struggle is an aim to maintain a certain amount of normalcy and to keep from society the fact that what is understood as anti-social mechanisms are in force. These mechanisms, representing socially

unacceptable cravings, come out in a distorted manner in the form of symptomatic acts, fantasy formations and a horde of different physical symptoms, the real fundamental picture of which is unconscious.

The psychotic individual is one in whom some repressions have entirely failed to the extent that the individual is expressing himself in part purely at an infantile or "perverted level" and in whom regression has taken place to an earlier state of behavior which is much more simple in its adjustment than growth and progression at the high adult environmental level. From time to time, the psychotic person through re-repression, which may be brought about in more than one way, is able to recover his former adjustment and take his place in society. Clinically, there is usually no difficulty in differentiating an outspoken or fully developed psychosis from a psychoneurosis, but at times the differentiation of a psychoneurosis from a "neurosis-like" condition of more definite physical significance, or from a beginning, a mild or an atypical case of dementia precox, is no easy matter, and not seldom is it necessary to await further developments in a given case before venturing a diagnostic opinion.

Since oftentimes the symptoms may appear not at the emotional behavior level, but consist almost wholly of physical expressions, the following points should be kept clearly in mind:

1. The temperamental makeup of the person, with par-

ticular attention to his manner of reacting to previous illnesses, and to the past vicissitudes of life.

2. The mental attitude of the patient toward his disease, and also the attitudes of the relatives toward his condition. Does he seem to be gaining a lot by being ill?

3. The particular environmental setting in which the disorder began.

4. The type of history of the illness, as to whether it conforms with the classical descriptions of physical diseases. Are there too numerous unaccountable deviations from the picture?

5. The nature of the physical signs and symptoms on examination. An evaluation must be made of the relevancy of the physical signs to the actual complaints of the patient, e.g. insomnia and fatigue must be considered from several standpoints as must also tremors, tics, muscular weakness, paralysis, headaches, tachycardia, gastric symptoms, etc.

(10)

HISTORY

From the earliest times, there are records among all people of the widespread character of this mechanism. Some of the historical landmarks of most interest are given in the works of Pommes, Brachet, Gilles de la Tourette, Richer, and Binswanger. Cesbron gave a critical history of hysteria in a Paris thesis in 1909, while the general historical aspects have been gathered by Jelliffe in the seventh volume of Osler's "Modern Medicine". It is interesting to trace the gradual

growth of interpretation concepts which have sought to explain the manifest phenomena called by various names at various periods by different physicians of the times. Certain features have remained fairly constant. These, however, have been among the most striking of the motor phenomena of hysteria, and it is not surprising that even at the present time the vastly more important and widespread, though more subtle, manifestations of hysteria should be overlooked.

The earliest hypotheses concerned themselves with more or less gross anatomical features, the earliest formulation of which gave the name to the disorder. It is said that Democritus first assumed that the wandering uterus brought about the reactions, and it is highly probable that the teachings of the Hippocratic school were faint echoes of previous modes of interpretations. The grosser beliefs in a wandering uterus were naturally more or less demolished by the careful anatomical studies of Galen who, showing that the uterus was a fixed structure and not capable of wandering substituted a bit of humoral pathology only slightly deviating from the original standpoint. No longer did the uterus itself wander, but the humors developing within the uterus, menstrual, or what not, being unable to find a satisfactory outlet became the cause of the phenomena. With the gradual growth of medical science the belief in gross humours, such as those just outlined, fell away. They only became more tenuous, however, and throughout the Middle Ages - even down to the first part of the Nineteenth Century, one heard of vapors, of gases, etc.-as causative of hysteria. The symbol

became more ethereal. Logic displaced the grosser superstitions, but has not entirely eradicated superstitious modes of interpretation, and thus we have the belief still persisting among animistic thinkers, in auto intoxications, and similar attenuated kinds of humoralism as causes for hysterical phenomena.

The transformation of the causative symbol from the grossly organic, wandering through humoralism to the thinly attenuated chemical poisoning, becomes more complete when the energetic concept passes from the physical to the psychical, and we finally have substituted a type of psychical determinism as productive of the phenomena. This is more in line with the general attitude of the times which views the central nervous system as a transformer of external energy rather than an originator of the same, and the present day energetic or dynamic concepts offer more plausible types of explanation to cut into the facts than have heretofore been presented. Such explanations will undoubtedly also have their day and the formula of "conversion of psychical energy into symbolic physical manifestations" will probably seem crude in the medicine of the future. Still, at the present time, the formula explains the manifestations better than the previous formulae and offers a more definite viewpoint from which to attack the problem of therapy, and some notes concerning its historical development may not be out of place.

(55)

The past history of hysterical concepts is interesting from the standpoint of variety but only since the beginning of the

modern period which is said to date with Charcot, do we get any semblance of uniformity, even though the views are couched in different terminologies.

These modern hypotheses may be grouped about three general centers, the psychological, the physiological, and the biological, in all of which the psychogenic factor is prominent. The chief psychological hypothesis, namely, that of dissociated personalities, received its first great impulse from Charcot himself and has been most attractively elaborated and made popular by his pupil, Janet, and even more intricately analyzed and extended by Freud and his school. For Charcot, hysteria was a psychoses, and Gilles de la Tourette is largely responsible for the prominence of the factor of suggestion in the after coming presentations; the extreme position of this feature alone having been advocated by Babinski, which author would seek to dismember hysteria further and give us a new grouping within this large medley, a task that Janet has also attempted as well as Freud. Pithiatism, psychasthenia, and the anxiety neuroses are the new entities partly separated out of the hysteria conglomerate, partly from the neurasthenic mass, and partly from the initial stages of the more frank psychoses, notably dementia praecox.

Of the Charcot followers, Mobius suggested the line of many later definitions. He called those morbid phenomena hysterical which were induced by ideas, and the physical as well as the psychical reactions had a common psychogenic origin. For him every one was more or less hysterical. Everyone has hysterical small coin in the bank of his personality. Gilles de

la Tourette's large monograph, published in 1891, is the most faithful elucidation and amplification of the Charcot doctrines. It, with Briquet's classic, has served as the modern fount of symptomatology.

At the present time it is recognized that the Charcot teachings were too fixed; they regarded hysteria in the light of an individual entity, almost in the formal light of a "species" within the limits of which were dragged a vast cohort of symptoms. Charcot described as an entity a "morbus" - where present day psychiatry sees a "cohors morborum", having really little in common, save a tendency to similar emotional reactions.

The stigmata of Charcot are not alone the apponage of a definite disease, they are more widely distributed; they are not the "stigmata diaboli" but the "stigmata necessitatis".

Probably no studies of hysteria in modern times have attracted so much attention as those of Pierre Janet, who has been so very prolific that it becomes almost impossible to give a short resume of his standpoint. His own abstract, given at the Amsterdam Congress in 1907 is perhaps the best available. The study of somnambulism is his starting point. For him there exists in consciousness a region below, if such a term be permissible, the normal waking or personal consciousness, which is called the subconscious. Groups of ideas may exist in this, so to speak, twilight region without being at all clearly perceived by an individual, in fact, without being at all known, and yet they may operate to produce results very much as if they

were the subject of voluntary attention.

The hysteric in an access of delirium lives through fancied experiences about which he knows nothing when he "comes to" - he has an amnesia for all these events. The hysterical amnesia does not confine its manifestations to such conditions but invades the details of life. The person who is sent on an errand, forgets what she is sent for before she is half way to her destination. This is a simple but common example. Janet would explain this by a disorder of attention. The directions are imparted to the patient but not acutely attended to, and drop at once into the region of the subconscious and are forgotten by the waking personal consciousness. The anesthetic arm is so because the patient does not attend to the sensations from the arm to perceive them. There is a narrowing of the field of personal consciousness which is but another way of expressing the defect in attention.

The synthesis of mental processes into a coherent whole constitutes the personality or ego, and the hysterical process causes a splitting, a disintegration or a doubling of the personality. Janet's definition is that "hysteria is a form of mental depression, characterized by the retraction of the field of personal consciousness and by the tendency to the dissociation and the emancipation of systems of ideas and of functions which by their synthesis constitute the personality". For Janet the hysterical and the hypnotic states are the same identical, based upon the common factor of suggestibility.

The theories of Sigmund Freud, of Breuer and Freud, and those

of the Freud school are modified by dissociation theories in which one finds more stress laid upon etiological factors. This is practically true of Freud's ideas which are of paramount interest to the student of mental problems since this author's work with that of Vogt's has proved a great stimulus leading to the interpretation of mental mechanisms.

Freud's hypothesis presupposes three features: (a) The role of psychogenesis, (b) Janet's ideas upon dissociation and psychical automatism, and (c) Binswanger's formulation of the etiological importance of the affect. As early as 1880 Breur advanced the interpretation that the individual roots of the hysterical symptoms were to be sought in ideational complexes with marked feeling tone which came about as a result of psychical or physical trauma, and in 1893 to 1895 Breur and Freud further formulated the idea that the psychoneurotic symptoms originated from the complex either by a process of (a) conversion, whereby the emotional (affect) excitement brought about abnormal physical innervation - this caused hysteria: or (b) by transposition of the affect through ideas (anxiety states). The principle of over-determination expressed the heaping action of an affect sufficient to determine a symptom. This same over-determination is more concretely and physiologically expressed by Cajal's concept of avalanche action.

The ground of the conversion or the transposition lies in the immiscibility of the traumatic complex with the personality. The patient refuses to accept it, and instead of ab-

reacting and thus normally disposing of the complex converts it or transposes it. The affect thus remains shut in or hidden in the subconscious.

Gradually Freud's attention became centered, and perhaps one-sidedly, upon the sexual nature of the original trauma. His general hypothesis is extremely intricate, and no short abstract does justice to the results obtained by his psycho-analysis, yet his present attitude may be expressed somewhat as follows: There develops, usually on a constitutional basis, in the period before puberty, definite sexual activities which are mostly of a perverse nature. These activities do not, as a rule, lead to a definite neurosis up to the time of puberty, which in the psychic sphere appears much earlier than in the body, but sexual fantasy maintains a perverse constellated direction by reason of the infantile sexual activities. On constitutional (affect) grounds the increased fantasy of the hysteric leads to the formation of complexes which are not taken up by the personality and by reason of shame or disgust remain buried. There therefore results a conflict between the characteristic normal libido and the sexual repressions of these buried symptoms. It is in his contributions to the sexual theory that Freud develops his later thoughts of the sexual origin of the hysterical reaction. By sexual it is important to remember Freud is not speaking of sensual.

Inasmuch as the sexual traumata are forgotten, buried

in the subconscious, it becomes necessary to dig them out by the process of psycho-analysis, either using Freud's method, or by the association tests so minutely and painstakingly elaborated by Jung and Ricklin particularly. In practice it may take months or years to fully analyze some hysterical cases. When fully analyzed, the patients become cured, the analysis has been a catharsis.

White has expressed the whole matter very clearly. He writes "The characteristic of the psychic traumata that produce hysteria is their large content of painful affect. A painful affect, fully reacted to at the time, may produce no harm, but if for any reason reaction fails, the feelings become repressed and the possibilities of dissociation are created. Failure of reaction may be due to the failure of conditions that make efficient reaction possible, as for instance, an insult "is swallowed", a dear friend or parent is lost, and no compensation is possible. This gives rise to "retention hysteria". Again, ideas usually of a sexual nature, which are incompatible with the personal consciousness, are repressed--abreactions is not permitted, no effectual catharsis takes place. This condition produces the "defence" hysteria. Finally, experiences occur in a hypnoid state - i.e. in a split-off dissociated, or dreamy state. They produce the so called hypnoid-hysteria."

"The final principle of the Breur-Freud hypothesis is the principle of conversion. The strangulated affect, the unreacted to emotion, belonging to the dissociated state which

has been repressed, finds its way into bodily innervation, thus producing the motor phenomena of hysteria. In this way the strong idea is weakened by being robbed of its affect - the real object of conversion."

"The significant feature of Freud's theory is the tracing of every case to sexual trauma during early childhood. Sexual experiences differ, however, from ordinary experiences - the latter have a tendency to fade out, while the idea of the former grows with increasing sexual maturity. There results a disproportionate capacity for increased reaction which takes place in the subconscious. This is the cause of the mischief.

"There must be, however, a connecting link between the infantile sexual traumata and the later manifestations. This connection Freud finds in the so called "hysterical fancies". These are the day dreams of erotic coloring, wish gratifications, originating in privation and longing. These fancies hark to the original traumatic moment, and either originating in the subconscious or shortly becoming subconscious, are transformed into hysterical symptoms. They constitute a defense of the ego against the revival, as reminiscences, of the repressed traumatic experiences of childhood."

"It is premature to pass judgment on Freud's ideas. They have their warm advocates and bitter opponents. They suggest the psychical archeologist grubbing about in the fragments of old, crumbling and mutilated memories with perhaps a tendency to romantic reconstruction. The method of the archeologist who reconstructs the entire animal from a single tooth is not called

in question, but it would seem not improbable that psychoanalysis, so called, might find the same type of "sexual fragments" in non-hysterical individuals, but Freud's "strangulated affects", "conversions" and "abreactions" have not yet been sufficiently subjected to critical tests to determine their real values." (57)

The physiological theory as propounded by Binswanger and Cajal stated briefly consists in the supposition that there exists a "functional" disturbance of the brain. A lowered or raised threshold for stimuli or over-whelming avalanche reactions as the result of various factors are assumed as the physiologic mechanisms. Wilson suggested that the more severe manifestations of hysteria represented physiologic analogues of decerebration.

The biologic approach to the neuroses deals with the instinctive reactions of the individual in his relation to the social group. Now, the instincts, mostly serve the needs of the individual, but the preservation of the individual has little biologic meaning unless his existence also serves the propagation of the race. The fact remains then that a constant struggle is observed between the inner urge of the individual to preserve himself and the tendency of the group to use him for its own needs. The struggle between the individual and the group which takes place at the instinctive level is often very keen and he who cannot mould his individuality to the needs of the group often reacts with a neuroses. This represents a flight

from reality and an attempt to evade the demands of life. The neurosis becomes an unconscious defense reaction: the sickness represents a great gain by sparing him the need of openly expressing fear or shame and yet saves him from the dangerous demands of society.

The behavioristic theory holds that all behavior is but a series of physiologic responses or conditioned reflexes. Training and experience alone account for the reactions. Provided one can establish the conditions one can create physiologic pathways, and, so to speak, make and unmake neuroses. Kretchmer says that hysteric behavior represents an "ontogenetically preformed type of reaction which arises from the primitive psychic soil." It is a purposive flight into sickness making use of biologically preformed mechanisms. (58)

ETIOLOGY

It is evident from the above theories that much is yet to be learned in regard to the etiology of hysteria. The great number of conflicting opinions is the best evidence of our inadequate knowledge. We have seen how one man attempts to explain hysteria entirely on a basis of heredity - another on the grounds of environment, and a third, as the direct result of an organic condition. Henderson-Gillepsie on the other hand impress one with the multitude of factors involved and say:

"It is customary to discuss etiology under a series of headings - as to sex, age, race, climate and what not. This does no harm so long as it is remembered that such items have no

necessarily specific etiological connection with a given case. A mental disorder is the sum of many conditions, and the end result of a long chain of processes. The earliest of these may have begun in the unfertilised germ-plasm, another may have operated in utero, and the rest may be the reactions of an organism thus handicapped to the aids and obstacles which it subsequently meets in the environment in which it finds itself - the influence of parents and teachers, the difficulties in the path of ambition and the ease as well as the hardness of innumerable situations in life. The first of these factors falls, in the usual scheme, under "heredity" the second under "congenital" and the next under the headings of age, sex, family, etc. But it is the ensemble of all such factors that is the "cause". An examination of our case-records shows that there is never in a given case one single etiological factor, but always a constellation of them. Moreover, the cause is not a bolt from the blue, nor a mysterious entity destined to implant itself at a certain epoch on unprepared soil; the "cause" is a process - something that moves and shapes itself in the passage of time." (53)

Dr. C. D. Fox has this fairly optimistic attitude toward heredity, "direct inheritance of hysteria may be possible but the more apparent deleterious effects of constant association of the offspring with a hysteric patient is sufficient to account for those instances in which the disease is encountered in two consecutive generations of a family. A broad-minded view of the part played by heredity in the production of hysteria is to hold

the opinion that the disease is potential in everyone, and that the potentiality becomes more decided when neuropathic heredity exists. Then the relationship between hysteria and direct heredity is practically the same as that in tuberculosis; direct inheritance of either disease being rare, and the usual character of transmission being that of increased susceptibility." (50)

Dr. J. A. McGeorge is of that school which lays great importance on the role of environment in the causation of hysteria. To quote from him:

"The term environment covers a great deal, it may refer to the home, the district or even the country, but the particular part of it with which we are here concerned is the more intimate one of the home, and especially of the parents and their influence on the growing child.

Child is a natural imitator, home ties are especially great before puberty and during this impressionable age the domination of one parent may mould the child in such a fashion as to determine its future behavior in adverse circumstances.

The positive element, as an excess of self-assertiveness in the parent, may produce the negative reaction of self abasement in the child, with a resultant dependence and lack of initiative which spell ultimate failure in life, when it is thrown on its own resources. This failure may be simply a material one, or it may be a psychological one contributing to the development of a psycho-neuroses or even such a psychosis

as schizophrenia.

It is a logical inference that the paternal influence is necessary to counter-balance an excess of maternal solicitude and tenderness. If the father plays little or no part in the home life, then the child is thrown entirely on the mother or her substitute, a nurse or a female relative. Should any of these deviate from the normal in any way, then a dangerous influence is at work which may so mould the child's behavior and conduct as to result in some degree of mental instability. It is not uncommon to find a child imitating the choreiform movements of its mother, or even the ungainly gait of hip disease. Why should this tendency not be extended to include modes of thought and temperament too?

Loury suggests a behavior equation in which individual plus situation equals reaction. He believed that the "child constantly experiments with the whole environment by the use of various modes of behavior, innate or acquired, to find situations in which the behavior is successful or in some way satisfying." If the mother is lax, the child will modify its conduct accordingly; the ^{re} will be lack of training and guidance, rendering it ill-fitted to cope with the problems which later will demand solution.

The author then quotes several cases and reaches the conclusions that environment is the dominating factor in determining the development of hysteria and that in 75% of the cases it is the sole predisposing cause which can be found.

Further, in 23% of these it is also given as a precipitating cause. The environment which is referred to is, of course, that of the home. Other factors seem to be negligible compared to this. Although some other form of psychic trauma may be advanced as the precipitating influence, it has been found that the actual origin lies much further back in life. Whether we accept the psycho-analytical explanation for this result of the loss of paternal element in the child's sexual life, or adopt the simpler suggestion that it is due to the absence of the father's controlling hand, the fact remains that this situation is of too common occurrence to be merely accidental and unrelated to the condition which develops. The psycho-neurotic seeds are sown before puberty, although the harvest may not be reaped until adult life is reached.

Various authors have discussed the aetiology of hysteria, but the majority seek only the actual cause of the present manifestations, and pay no attention to those factors which predispose to it, although admitting that there is a neuropathic constitution which reacts adversely to various mental stresses. Stoddart suggests as aetiological factors, superstition and religious excitement, fright or shock, traumatism and an aberrant sexual instinct but does not explain why certain people should react so markedly to these, while normal individuals are not affected by them. Babinski goes further and states definitely that "predisposition, personal or hereditary antecedents, the nature of the individual and the emotional con-

stitution appear to be of secondary importance."

This is surely a sweeping statement to make, especially as he offers nothing in return but suggestion and traumatism, two influences which cannot be said to have played more than a very minor part in the cases of our series.

No lasting good can be hoped for in any mental or physical disorder unless the condition is attacked at its source. It is futile to treat symptoms alone and neglect the disease itself, and that is exactly what is too often done in hysteria. Therapeutic measures may ameliorate or cure the present condition, but still have the underlying neuropathic constitution untouched. Recurrences are only too frequent and the manifestations of hysteria may be protean in the same individual.

The greater growth of the study of mental hygiene which devotes considerable attention to childhood and environment, may later produce results by correcting a faulty situation, or advising the parents concerning the correct attitude to be adopted towards the malleable and impressionable child. In this appears to be the only hope of the ultimate salvation of the unfortunate individual who is otherwise doomed to a life of dependence, maladjustment and psycho-neurotic aimlessness. (6)

Dr. J. A. Holland, although admitting environmental influences as an etiological factor in mental disease, gives it but passing recognition. In his estimation the underlying basis is definite demonstrable organic pathology, and even though it may be obscure can be shown to exist in every patient

without exception. After enumerating the most likely sources of infection, he goes on to say:

"Inasmuch as such pathology exists, it is only reasonable to believe that mental illness is the result of chronic infection and can be said to be a chronic delirium, resulting from chronic toxemia, as an acute delirium results from an acute toxemia. There is no fundamental difference in regard to symptoms shown. It is merely a question of severity and time, the symptoms being the same in each condition. It has always seemed ridiculous to me that although an acute delirium is easily recognized as the results of pneumonia, typhoid fever, acute tonsillitis, and other overwhelming infectious diseases, chronic delirium, showing exactly the same symptoms, should be classed by the first school of psychiatrists as an abnormal function of the mind, due to sexual repressions, business worries, family quarrels, disappointments in love, and so on. All of these, of course, have some bearing, on the personality of the person but are not causative factors in the occurrence of mental disease unless physical ill health exists also." (54)

SYMPTOMS

"The general symptoms of hysteria are so numerous that it is almost impossible to discuss them in detail without making a text encyclopedic. Nor is it necessary. Provided one understands the mechanism of their causation (psychogenic origin), and realizes that there is hardly a sign or symptom of organic disease which hysteria cannot simulate, it is sufficient to

describe briefly the more common and characteristic manifestations. Hysteria is the most protean disease in the whole domain of medicine. While "monosymptomatic hysteria" is not at all uncommon, by far the greatest number of cases present a great variety of manifestations which are almost a kaleidoscopic in their nature. Prominent in the list of varied symptomatology are perversions of sensation:

(a) Pain - increased sensitiveness and pain may occur all over the body. The hysterical pains may be "neuralgic, migrainous or rheumatic." The patient speaks of them as "terrible", but generally shows a certain detachment, if not indifference. Hysterical headache, on close inquiry, often turns out to mean severe pain and hyperaesthesia of the scalp. This localized pain and tenderness, spoken of as *clavus*, consists of a sensation as if a nail is being driven into the head. The location generally is in the temporal and parietal regions and its duration weeks or months. Pain in the back is another common and persistent complaint. Sometimes it is diffuse, at others localized to one spot. If severe, it may be accompanied by rigidity of the muscles and curvature of the spine. This typical forward bending of the back is known as compto carmia and is not infrequently observed following trifling trauma to the spine. After a time it amounts to hysterical contracture, the patient walking with the body bent forward

almost to a right angle, the head turned upward. The pain may be limited to the tip of the coccyx (coccygodynia), to the breast (mastodynia), or any part of a limb. The abdominal pains may simulate any organic condition, from gastric ulcer to cholecystitis, appendicitis, renal calculus, etc. and lead both to erroneous diagnoses and fruitless operations.

(b) Hyperesthesia - this too is a very common symptom the extreme tenderness being out of all proportion to the immediate stimulus. Localized hysteric tenderness has given rise to the conception of hysterogenic zones which were formerly made use of either to elicit or cut short a hysteric attack. These local tender points are generally found in various regions of the spine, the breasts, epigastrium, inguinal regions (ovarian), or the head. A peculiar dysesthesia of the tongue and mucous membrane (glossodynia) consists of a burning, itching pain, and is generally found in edentulous women past the menopause. This is a stubborn condition, frequently accompanied by fear of cancer. In such cases it is very important first to rule out early pernicious anemia. Hyperesthesia of the eyes sometimes shows itself in photophobia. Dancing spots before the eyes and noises in the ears also are very common hysteric complaints. Obersteiner described a perverted sensation known as allocheiria, which consists of the perception of the sensation on a corresponding part of the

body or limb when the other side is touched. Some patients, probably always as the result of suggestion, perceive pain when touched by metals or other objects which convey temperature sensations.

(c) Anesthesias - while not nearly so common as was once believed, occasionally occur. Diminution of sensation is more common. These anesthesias are not limited to typical neural distributions but involve a limb or a part of a limb (glove and stocking), half of the body and the mucous membranes (vagina, rectum, nose, mouth, pharynx). They are frequently, but not always, due to suggestion on the part of the examiner. Peculiar of the anesthesias is the usual involvement of all forms of superficial and deep sensation without that dissociation which so often occurs in organic sensory disturbances. If the sensory loss is limited to one-half of the body, it is found to stop exactly in the mid-line, a condition which is contrary to the normal cutaneous overlapping. Similar psychogenic loss of sensation is attested by the hysteric's perception of the tuning fork on one side of the head - an evident impossibility in view of the normal conduction of vibration. Loss of smell, taste, and hearing together with the hemianesthesia which includes the face, is further evidence of the hysteric origin. On the other hand, despite the loss of sensation and the ability to prick deeply with a pin (the faradic brush may nevertheless be felt), the psychogalvanometer may show

deflection of the needle on painful stimulation. This would prove that the stimulus is perceived. Bilateral anesthesia is very rare. Contrary to organic loss of sensation, the hysteric anesthesia often disappears as suddenly as it came, not infrequently as the result of auto or hetero-suggestion.

Hysteric anosmia is rare as an isolated symptom, but when it occurs affects the perception not only of odors but also of pungent substances which irritate the trigeminal nerve. The hysteric may lose the sense of smell for certain substances only, or relish the offensive odor of valerian, asafoetida, or excreta. Irregular contraction of the visual field is the most common psychogenic disturbance of vision. Generally, one eye shows more contraction than the other and sometimes the field grows smaller as the perimetric examination is repeated. True hysteric hemianopsia is rare, although it has been described. Bilateral hysteric amaurosis is very rare, unilateral more common. Dyschromatopsia and achromatopsia, which consist respectively of perversion and loss of color conception, are also rare. Hysteric blindness is apt to come on suddenly after an emotional shock or trauma (to which the patient would shut his eyes), and after lasting minutes, hours, days, weeks, months or even years, disappears as suddenly. The hysteric amaurotic is not apt to bump into people, and the pupils react. In unilateral hysteric blindness

one may be able to produce diplopia with prisms. A good test is to blind the seeing eye with a powerful lens, cover the affected one with a plain glass, then ask the patient to read. In actual blindness this is impossible. Photophobia and blepharospasm frequently accompany hysteric affections of vision. What is known as dysopsia algero is painful vision. Hysteric myopia occasionally occurs in connection with spasms of accommodation. Monocular diplopia, a manifest physical impossibility, is another hysteric symptom. Finally, one may mention micropsia, in which objects appear very small, and macropsia in which they seem large.

(d) Motor Disturbances - Hysteric paralysis has become a comparatively infrequent phenomenon in civil practice, but it does occur sufficiently often to confuse the runaway. The paralysis may be partial or complete, flaccid, or accompanied by contractures. Generally, it involves half of the body, a limb or part of a limb, a function rather than a muscle or group of muscles innervated by certain nerves. The hysteric makes no effort to move the part, he is physically indifferent to it. There is no atrophy, at least not for a very long time - no loss of reflexes, and no reaction of degeneration. Pains occasionally accompany the paralysis. After a time contractures appear in the fingers and toes, hands and feet. These contractures are often extreme, the limbs being in a hyper tonic state. The hysteric

hemiplegia generally is flaccid, the patient dragging the leg rather than spastically circumducting it as inorganic lesions. The face and tongue often escape and the platysma always does in psychogenic hemiplegia. Nevertheless, hysteric glosso-labial spasm with deviation of the tongue may occur. Hysteric pseudoptosis, which is due to contraction of the orbicularis rather than paralysis of the levator, is characterized by absence of compensatory wrinkling of the forehead, such as occurs in organic paralysis.

(c) Hysteric astasia - abasia is an inability to stand or walk despite the normal ability to move the legs when lying or sitting. Children are much more affected than adults. Except as war hysteria this condition is quite rare. In staso-basophobia the patient is seized with anxiety if he is made to walk, clutches for help, and crumples up as his support is taken away. The hysteric gait is nondescript, bizarre, or pseudoataxic, the legs being flung in all directions. Some patients are able to crawl, swim, or run, but not to walk. Dragging a hemiplegic leg is a common hysteric gait. Akinesia algera is the inability to walk because of pain which cannot be accounted for. The deep reflexes in hysteric paralysis are generally lively and so are the superficial, except possibly in anesthetic areas. Pseudoclonus is sometimes present, but never a Babinski

sign. In-continnence of urine, except purposive is never present, but dysuria and retention are fairly common and so is hysteric enuresis. Pollakiuria, or very frequent micturation, is a very common hysteric symptom.

Hysteric aphonia is the most common form of psychogenic paralysis. It generally comes on suddenly after some emotional shock, and often disappears as suddenly. The patient can only whisper though he may be able sometimes to sing or cry out. The adductors are found weak on laryngoscopic examination and the larynx is anesthetic. The condition frequently recurs. Hysteric mutism is more rare. It differs from aphasia in that the patient can write or otherwise express himself by gesture, and from schizophrenic catatonic mutism by the absence of psychotic manifestations. Hysteric aphasia is a doubtful entity and bears little resemblance to true aphasia. Hysteric stammering or other articulatory difficulties also come on suddenly after some emotional trauma. Unlike the true stammerer, whose speech disturbance generally begins in childhood, the hysteric is rather indifferent to his speech defection and does not show the emotional reaction of the stammerer to difficulties of enunciation.

Reflex paralysis, described by Babinski and Froment, is not a true hysteric condition, although psychogenic palsy may be engrafted on the organic background. The

condition generally follows trauma to a limb, sometimes immediately, occasionally only after a few weeks or months. The amount of paralysis generally is out of proportion to the intensity of the trauma. The paralysis may be spastic or flaccid. Usually the affection is painful, the limb is colder than the healthy one, the skin and nails may show vasomotor and trophic changes, and the deep reflexes are lively. However, despite the evident organic signs the paralysis is greater than the minimal injury is responsible for, or lingers on after recovery ought to set in. There is, therefore, a marked psychogenic factor even though the paralysis is not altogether hysteric as was originally thought.

Hysteric contractures, which involve various points or whole limbs often follow paralysis. They consist mainly of flexion of the fingers and fixation at the knee or hip joints. Paraplegic contractures, torticollis, trismus, kyphosis, scoliosis, or lardoses may occur. Generally, attempt to overcome the contractures only increases them. After prolonged duration they may become permanent, but in the beginning they disappear under hypnosis or chloroform. The contracture may or may not cease at night. No organic signs accompany the contracture, but some atrophy may appear after some long duration.

Among the hysteric hyperkinesias may be mentioned tremors, tics, myoclonias and various spasms. There is

hardly an abnormal involuntary movement which cannot be caused by psychogenic disorders. Generally they are purposive and have a definite pattern. There is a certain stereotypy to them. Tics of the head, face and limbs, and abdominal myoclonias are particularly common. Hysteric cough, hiccough, yawning, and belching are also very common. The hiccough, which is caused by spasms of the diaphragm, often expresses itself in crowing noises. Globus hystericus may possibly be classed among the spasms. Esophagospasm with hysteric dysphagia and pylorospasm also belong to this group. In all these abnormal movements it is imperative to rule out organic disorders and establish a psychogenic origin. The fact that they are precipitated or aggravated by emotion and disappear at night is not by itself sufficient to establish their hysteric nature. (58)

Dr. A. Sinamark, in an article on Globus Hystericus states that invariably the O. R. L. man is the first to see such a patient. He characterizes the condition as follows: "The patient has a peculiar throat trouble which she believes to be very serious. She feels a "ball", "lump", or "pressure" in the neck and can't relieve the situation by swallowing. The sensation usually starts later in the day when the individual is tired and never when she is enjoying herself. She is of a nervous disposition and moreso since the trouble began." After a very thorough physical examination which is invariably negative and a heart to heart talk, 90% of his cases were promptly alle-

viated. As outstanding precipitating factors worry, - sexual troubles, and monotony were prominent. (1)

Dr. P. P. Barker, gives some very helpful points to consider in making a diagnosis of hysterical paralysis. He opens his article by stressing the factors of poor heredity and high degree of suggestibility as prime etiological considerations. The diagnosis is made on consideration of these facts:

1. The history is exaggerated and not in agreement with subsequent findings.
2. The patient treats his paralysis very indifferently and makes no attempt at movement. He considers his condition hopeless, is eager to justify it and makes no endeavor to move the limb.
3. The paralysis is more complete than is the case with organic conditions. It is not in accord with the anatomic distribution of the nerves.
4. The electrical reactions in hysterical paralyzed limbs are normal and the reflexes are usually normal, but may be exaggerated.
5. Absence of the reflexes or the presence of pathological reflexes, as the extensor or plantar reflex, indicates organic disease. (27)

Without going into unnecessary detail, it may be stated that visceral conversion hysteric phenomena and vasomotor disturbances are among the most frequent complaints of the patient, and often tax the skill of the most conscientious practitioner.

It seems convenient at this time to say a word about the so-called "stigmata" of hysteria as well as the confusing makeup which such an individual presents to the analyst.

"Stigmata" are only accidental phenomena, which, except when created by reason of faulty methods of examination are rather unusual or rare. If one wishes to establish such a premise, however, he should consider as outstanding the pathologic increase in suggestibility. A fact to be borne in mind, one which a priore must be true is that each person's hysteria must differ just as the mental characteristics of all individuals vary. Moreover, the kind of symptoms possessed by a patient depends entirely upon the nature of the incidental exciting causes, upon the personal equation, upon psychic contagion from others, and upon the affects of accidental suggestion. (47)

An insight to the characteristics of the hysteric is afforded by S. Paton who believes that these individuals fall rather easily into a definite category, a view which I might add has more than this one side.

"A hysterical individual will always hesitate about beginning a new series of movements and when told to do a certain thing, he may make the attempt, but the effort is feeble, spasmodic, and soon fails. Such individuals give one the impression of being unable to gather up sufficient force at the outset to overcome an initial resistance, and for this reason an act when once committed is frequently repeated and becomes in time partially automatic.

These abulias in hysteria exert a marked reflex effect

upon the whole mental attitude of the patient. The totality of the emotional reactions in hysteria is reduced as compared with those occurring in the healthy normal individual. Only a comparatively few stimuli - the insistent ideas - serve to awaken an emotional response. The hysterical individual can hardly be regarded as a person with broad interests; he usually becomes cynical and narrow-minded in regard to everything that does not immediately pertain to himself. On the surface he may be apparently generous and disinterested, but when his character is closely studied, it will seem that there has come about a great narrowing of the intellectual horizon. These anomalous emotional states are often well marked and explain both the general attitude of the hysterical patient to his immediate environment as well as his general loss of interest, as a consequence of which he is usually found to be devoid of altruism and markedly deficient in many social instincts, so that he frequently expresses a longing to be left alone and seems desirous of becoming more or less isolated. Nevertheless, on account of his impressionability, a paradoxical situation develops in which noble sentiments, such as those of gratitude or sympathy, are passionately expressed, but as promptly forgotten.

The hysterical modifications in character are very varied and incongruous and the disturbances in sensation, attention, and memory in turn give rise to a dissociation of the personality. No single feature of these anomalies of character is as constant as their inconstancy. Hysterical individuals are incapable of any prolonged effort for the reason that they lack the power of con-

centration and because the focus of their attention is constantly changing.

In addition to these changes already noted, hysterical patients are apt to be exceedingly selfish, this trait manifesting itself in a great many different ways and being the direct result of the dissociation which occurs in personality. Such individuals seem so absorbed in their own tiny world, that they fail to grasp in any sense their relationship to their immediate family and friends. This symptom is the result of the general mental impairment as well as of the diminution in the number of the emotional reactions. Hence, it is not surprising that hysterical individuals show remarkable inconsistencies in character, and these in turn are dependent on the physical defects in function to which reference has already been made. Prominent among the mental idiosyncrasies of these patients is a tendency to lie. This failing is often referable to the same cause as that which engenders untruthfulness in children, namely, - fear. In many instances hysterical individuals have a strong tendency to deceive on account of a desire to conceal their defects combined with a craving for sympathy from others. The abnormal activity of the imagination in hysterical patients is another fertile source of their lack of veracity. These Munchausen-like narratives not infrequently refer to extraordinary scenes through which the individual has passed or to events that have occurred in his daily life." (45)

Of all the countless hysterical symptoms, perhaps the most dramatic, both to the laity and to the medical profession,

are the so-called psychic or mental phases. These include somnambulism, fugues, amnesias, double and multiple personalities. Hardly a day goes by without a case of amnesia appearing on the newspaper front page.

To Janet the state of somnambulism is the keynote for the analysis of a hysterical.

"I ask you to put in the first line, as the most typical, the most characteristic symptom of hysteria, a morbid symptom, that is, somnambulism. If one understands somnambulism well, one is, I believe capable of understanding all hysterical phases that are more or less constructed on the same model.

Things happen as if an idea, a partial system of thoughts, emancipated itself, became independent and developed itself on its own account. The result is, on one hand, that it develops far too much, and on the other hand, that consciousness appears no longer to control it." (45) (52)

Fugues differ from monoideic somnambulist states both in regard to time and content. A fugue lasts much longer than a monoideic somnambulism. While the latter lasts for a few hours at the most, the former lasts for months together. It is necessary for a fugue to be able to last so long that the state should approach the normal state, and that the character of somnambulism should be attenuated. In polyideic somnambulisms and in fugues the dissociation has taken place on a feeling or an emotion in contrast to the ideas relative to an event- that is- mother's death is a well-defined system which can be suppressed clearly or can dev-

elop separately, E.G.- The feeling that arises from the fear of an ignominious charge, the feeling of love and jealousy toward a lover-etc. these are systems of thoughts that it is not always easy to express in words, that are not ideas, properly so-called, that may on the contrary ^{involve} very many different ideas but that nevertheless possess a mental unity.

Pitres defined a fugue as a "pathologic syndrome appearing in the form of intermittent attacks during which the patient leaves his home and makes an excursion or journey justified by no reasonable motive. The attack ended, the subject unexpectedly ^{finds himself} on an unknown road or in a strange town".

"Raymond in 1895, gave as the three cardinal symptoms of fugue (1) an irresistible impulse to travel, (2) traveling accomplished in a regular, intelligent manner without mishap and (3) at the end of the impulsive action, complete loss of memory or amnesia covering the whole period of its duration.

A fugue may or may not be a feature of one of the personalities in dual or multiple personality. Somnambulism may be regarded as a fugue during sleep. There is no small amount of difficulty in differentiating a hysterical from an epileptic fugue, the latter occurs about 20% of the time. The normal state of the patient rather than that of the fugue should be the basis of consideration (12.)

A very helpful differential between organic and hysterical amnesic periods is given by Strecker-Ebaugh. (43)

POINTS IN DIFFERENTIAL DIAGNOSIS BETWEEN ORGANIC AND HYSTERICAL AMNESTIC PERIODS

	Organic	Hysterical
Characteristics of amnesic period		
1. Onset.....	Usually abrupt and sharply defined. If precipitated by head injury there is often also amnesia for events preceding the injury for two or three hours.	Usually given by patient as abrupt, but frequently there is some vagueness as to exact time of onset. No loss of memory for events preceding onset.
2. Recovery.....	The actual period for which there is amnesia usually disappears suddenly, over a period of one to two hours a day, often after a profound sleep. Mild confusion with difficulty of orientation may persist for a day or two afterward.	Recovery abrupt with mental clearness and accurate orientation. There may be some vagueness as to time of actual termination of amnesic period.
3. Precipitated by.....	Occur spontaneously or following actual head injury, and may occur at any time.	Almost invariably precipitated by definitely traumatic emotional experiences.
4. Behavior.....	Often confused and bizarre with evident lack of emotional control. Often dissociated, cruel or gruesome acts, or delirium.	Usually purposeful and carrying out a continuous project associated with some definite previous experience in patient's life. Contact with surroundings maintained.
5. Physical examination.....	Will often show evidence of head injury; brain tumor, focal or general neurological signs, etc.	Reveals no characteristic picture. Often there is constriction of sensory functions. Most commonly contracted visual fields or localized, atypical losses of tactile sensation.
Post-amnesic period		
1. Memory loss.....	Characteristically a complete loss of memory for all events during period of fugue which cannot be reconstructed by any means whatever.	Characteristically a complaint of complete loss of memory for events of fugue episode but isolated events during the fugue may be remembered, and all events can be reconstructed completely by associative methods or hypnosis. Events preceding the period of amnesia are usually clearly remembered.
2. Personality type.....	Often distorted into instability and irritability accompanying organic brain disease. Not necessarily typical of any personality syndrome.	Typical hysterical personality type with hypomanic or depressive characteristics and often showing other functional disturbances during interval between fugues.
3. Physical examination.....	There may be specific evidence of syphilis or other organic brain disease by increased spinal fluid protein and cell counts, positive Wassermann, etc. or often in epileptic cases decreased spinal fluid protein.	May be similar to that during fugue period. Characteristically normal findings.
4. Serological.....		

DOUBLE AND MULTIPLE PERSONALITY

The somnambulisms which we consider as the essential phenomena of hysteria are apt to present a new metamorphosis whose scientific interest is very great when they are so protracted and complicated as to give rise to what is called double existences, double personalities. The essential phenomenon that in my opinion, is at the basis of these so-called double existences, is a kind of oscillation of mental activity, which falls and rises suddenly. These sudden changes, without sufficient transition, bring about two different states of mental activity, the one higher, with a particular exercise of all the senses and functions; the other lower, with a great reduction of all the cerebral functions. These two states separate from each other; they cease to be connected together, as with normal individuals through gradations and remembrances. They become isolated from each other, and form the two separate existences. Here again, there is a mental dissociation, more complicated than the preceding ones. There is dissociation, not only of an idea, not only of a feeling, but of one mental state of activity. (52).

The dividing line between ambulatory automatism and multiple personality is purely arbitrary; a fugue being a lower form of dissociation which eventuates in a flight.

Multiple personality consists in the alteration of two or more distinct personalities the sum of whose distinctive characteristics roughly speaking is equivalent to what

should be the normal personality of the individual. Dissociation of the personality implies a division of the personality, and consequently, the faculties of one state often are at the expense of another. In other words they are complementary. For this reason, a hysteric is never cured, no matter what may have been her symptoms of disease, unless all of her pathologically dissociated memories have been restored to consciousness.

In several of the early instances a patient with a hysteria in whom the existence of multiple personality was not suspected, was hypnotized for the purpose of attempting to remove symptoms, and that while in this condition the patient appeared to be normal and well, what was believed to be a hypnotic state was allowed to persist when, in reality, it was the normal personality, except for loss of memories of the secondary state.

Although convulsive hysterical attacks can hardly be considered with double and multiple personalities the basis is the same, namely a somnambulism. The subject, after more or less protracted struggling, seems to wake up all at once or gradually, sets her dress to rights, and, almost without any difficulty, gets up again and resumes her former occupation. Here is to be noticed a great medical fact; namely that the hysteric fit does not seem to bring about a great physical disturbance, as the epileptic fit does. The subject is not exhausted- she has not the stupefied, haggard aspect of an aw-

aking epileptic, nor the irresistible need of sleep which characterizes the comitial fit. Our hysteric patient, after howling for several hours, feels rather comfortable; she experiences as it were, a relaxation, and declares she is much better than before the fit. Another characteristic phenomenon is that she attaches no importance to what has happened; she is not in the least ashamed of her cries, her indecent attitude, nor the disorder of her acts. (50).

PATHOLOGY OR MECHANISM OF HYSTERIA

We have already discussed much about mechanisms in hysteria and yet its importance permits us to stress again the more important points as well as to elaborate on Freud's conception of the subject.

"The theories of Janet regarding "restriction of the field of consciousness" have already been considered. They give a very apt description and theoretical formulation of hysteria as an established condition; but except that the hysterical dissociation is said to occur at moments of great emotion, Janet's hypothesis does not offer an explanation of what brings the dissociation to pass. Freud supplies this deficiency. According to him, the hysterical symptom is the result of a conflict between the ego and some wish "which is not palatable to this ego, and which the latter represses. The repression, however, is only partially successful; the wish although repressed into the unconscious, succeeds in obtaining a disguised expression by "conversion" into the symptom "which is therefore in a sense a symbol.) Freud used to believe, however, that a necessary condition for the development of hysteria is a sexual trauma (real or phantastic) in early childhood. This trauma has undergone repression, and the repression only fails in later life when some contemporary event reactivates by association the memory of the trauma. Sexual trauma is no longer the Freudian sine qua non. Regression is sufficient - an infantile type of (forbidden) love object is

again sought for, or in other words a repressed Oedipus-complex dating from early childhood is the necessary condition for the development of hysteria in adult life. The memory and the wish are alike sexual. The localisation of the physical sign or symptom is determined by various factors - especially the appropriateness of the particular sign or symptom to symbolize the repressed wish, but also by accidental factors such as previous physical disability such as a wound.

The freudian explanation can hardly be accepted as having universal validity; it is impossible, for example, to see anything sexual in the aetiology of hysteria occurring in the soldier on the field of battle (although Freudians have a hypothesis on this subject conforming with the libido theory), or in peace time as the result of injury involving questions of compensation.

Rivers put forward a general biological hypothesis, which regarded hysterical symptoms as the expression of a phylogenetically ancient instinctive reaction (usually that of immobility) which was substituted for higher active forms of reaction to danger.

These theories have this in common, that they are narrow and insufficiently elastic. Hysteria is more than a symptom or a collection of symptoms. It is a special type of reaction to difficulties, which seems to occur chiefly or entirely in persons predisposed partly by inherited factors, and partly by their personality, and by environmental conditions, such as home and scholastic training. The essential characteristic of the

clinical picture in all its manifestations is the dissociation (splitting off and independence) of the mental representation of one or more functions. The possibility of such dissociation lies in the predispositions already mentioned. Its actual occurrence depends on the problems which the individual encounters in his way through life. The symptom is symbolic in the sense that it has a meaning for the patient. This meaning is eventually purposive, the symptom being a solution, however unsatisfactory, of some problem of every day adaptation. The patient is unaware of the real meaning. If he thinks about it at all, he believes the symptoms mean simply an illness in the ordinary sense. From these two facts - that the symptom is a solution of a problem, and that it is misinterpreted by the patient's consciousness - arises the patient's "belle indifference". The onset of the symptom may not always involve repression, but only a mental conflict without repression. The conflict leads to emotion and its physical manifestations. These are misinterpreted as the outcome of physical disease, and physical disease suggests disability of the part affected. Suggestion operates powerfully where there is mental conflict, and as the suggestion of disease is in harmony with one side of the conflict, the desire to escape the suggestion is accepted, and the symptom results. There is a gain of mental composure, since the conflict is solved, but at the expense of part of the personality, since suggestion operates primarily at the mental level, and can isolate a function only at that level. The actual problem may remain in the patient's mind, but it is no longer acute, since

symptom has provided a solution of an indirect kind. But the connection between the problem and the symptom is not seen by the patient. The connection cannot be said to be so much repressed as neglected. Only in some such way as this can it be explained that in many a psychological analysis of hysteria nothing that was not conscious before - although it may not have been clearly defined, or alluded to - may be brought out, and yet the symptoms disappear as their causations and connections are exhibited.

Where repression does occur, the same processes will serve to explain the occurrences of symptoms. For the production of symptoms at all means a partial failure of repression; if repression has partly failed, conflict conscious or unconscious exists, and conflict is the condition that led to the formation of symptoms in the way already set forth. These theories hold for the physical symptoms of hysteria.

With the mental symptoms of hysteria, a similar process occurs. In hysterical amnesia, for example, there has been a period of conflict; then emotional preoccupation prevents the subject's noticing events in the ordinary way, consequently the memory of them, when the conflict has died down (they are registered marginally), is vague; vagueness of memory suggests complete failure of it, the patient does not wish to remember in any case - again the emotional symptom coincides with the wish - we accept what we wish to believe, and so does the hysterical patient - an an amnesia results.

An exactly similar process will account for fugues - the patient starts out on her fugue simply with a consciousness whose clearness is disturbed by emotional conflict, and ends with an amnesia. In a fugue there need not be repression at the beginning - the amnesia is an end-product. Where a fugue habit has once been established, however, dissociation appears to occur at the beginning of each fugue." (53)

Freud has written in great detail on the "Psychical Mechanism of Hysterical Phenomena". As has been mentioned above, much which he offers is now considered as one-sided, but his reasoning seems so logical that I will set forth in the following few pages his trend of thought, and let the reader decide for himself how much he wishes to accept.

It is usually impossible to discover the starting point or event which led to the hysterical manifestations. This is due partly to the oftentimes disagreeable experience which was undergone as well as to the more important fact that he really does not remember and has no idea of the casual connection between the exciting occurrence and the pathological phenomenon. As a rule it is necessary to hypnotize the patient and under the hypnosis to arouse recollections relating to the time when the symptom first appeared; one can then succeed in revealing the connection in the clearest and most convincing manner. For the pathology of hysteria the accidental factor is more decisive than is known. In regard to traumatic hysteria, it is obviously the accident which has evoked the syndrome.

Experience has shown, however, that the spontaneous and,

so to speak, idiopathic products of hysteria have just as strict a connection with the exciting trauma as those mentioned above in which the relation of the two sets of facts to one another is transparent. The disproportion between the many years duration of an hysterical symptom and the single occurrence which evoked it is similar to that which we are accustomed to see regularly in traumatic neuroses, it was quite frequently in childhood that the events occurred producing a more or less grave symptom which persisted from that time onwards.

In many cases the relationship between the exciting event and that particular symptom manifested is very clear cut. For example, a highly intelligent man assists while his brother's ankylosed hip is straightened under an anesthetic at the instant when the joint gives way with a crack he feels a violent pain in his own hip which lasts for almost a year. In other cases the connection is not so simple; there exists only what may be called a symbolic relation between the cause and the pathological manifestation, such as normal people fashion in dreams; for example, a neuralgia links itself onto some mental distress, or vomiting accompanies a feeling of moral disgust.

Freud draws an analogy between ordinary hysteria and traumatic neurosis - to continue - in traumatic neurosis the active cause of illness is not the trifling bodily injury but to the affect of fright - the psychic trauma. Similarly, our investigations of many, if not of the majority, of hysterical symptoms have revealed causes which must be described as psychic

traumas. Any experience which rouses the distressing affects of fright, apprehension, shame or psychical pain can have this effect and it obviously depends on the sensitiveness of the person concerned whether the experience acquires the importance of a trauma. We not infrequently find in ordinary hysteria several partial traumas instead of one grand trauma - a group of causes - which can only achieve traumatic effectiveness by accumulation and which belong together only insofar as they may form part of a whole painful experience."

Freud made the discovery that with the clear recollection of the exciting event in conjunction with its accompanying affect the various hysterical symptoms disappeared at once, never to return. But recollection without affect is nearly always ineffective, the original psychical process must be repeated as vividly as possible, and then talked out.

To make the mechanism of the hysterical phenomena more evident, he goes on to explain how and why it is that some experiences long since past should operate with such intensity, and that the memory of them should not succumb to the fate which we see overtaking all our memories. He maintains that for the normal forgetting of an experience, a suitable reaction (discharge of feeling) must take place. If the reaction occurs with sufficient intensity, the affect wears off. This reaction may take several forms - crying ones' self out or actual physical retribution being common methods of expression. The process of giving vent to one's psychic trauma by speech is referred to as

"abreaction" and is a suitable measure for preventing the memory of a painful occurrence from retaining its affective tone. The remarkable thing about so many of these painful experiences is that they are absent from the patient's conscious mind or exist in the most summary manner. Only on being questioned under hypnosis do these memories recur with the undiminished vividness of recent events.

Let us now consider the conditions under which suitable reaction or the ordinary processes of memory effacement do not occur.

In the first group are those cases in which the patient has not reacted to the psychical trauma because its nature excluded the possibility of any such reaction as in the case of the apparently irretrievable loss of a beloved person, or when social conditions made a reaction impossible, or when the trauma concerned something which the patient wished to forget and therefore deliberately repressed and excluded it from his conscious thoughts.

The second group of conditions is not determined by the content of the recollection, but by the mental condition of the patient when the given experience occurred. That is to say, among the exciting factors of hysterical symptoms we also discover under hypnosis certain ideas which though not in themselves significant, owe their preservation to the circumstance that they happen to coincide with a seriously disabling affect, for example, terror, or with a directly abnormal mental condition, such as the half-hypnotic twilight state of day-dreaming, auto-hypnosis,

and the like. In these cases it is the nature of these conditions which made a reaction to the experience impossible.

Thus, it may be said that the ideas which have become pathogenic are preserved with such freshness and affective force because the normal process of absorption by abreaction and by reproduction in a state of unrestrained association is denied them.

It is now clear how the method of light hypnosis leads to recovery. By providing an opportunity for the pent-up affect to discharge itself in words the therapy deprives of its effective power the idea which was not originally abreacted, by conducting it into normal consciousness (in light hypnosis) it brings it into associative readjustment or else dispels it by means of the physician's suggestion, as happens in cases of somnambulism combined with amnesia.

Freud concludes his explanation on hysterical mechanisms by admitting that it is only the mechanism of the hysterical symptom that has been brought within our grasp and not the inner causes of hysteria. "We have but touched upon the aetiology of hysteria and have really only been able to throw light on the causes of its acquired forms - the significance of the accidental factor for this neurosis." (46)

DIAGNOSIS

Some of the more important pathological conditions which may confuse one in attempting to make a diagnosis of hysteria have already been discussed in detail previously; these were organic paralyses and contractures, psychoses, epilepsy and organic fugues and amnesias. This discussion will be limited to a few general facts which must be closely borne in mind before making a diagnosis.

In the first place, the examiner should approach each case with an unbiased conception of the disorder. Since hysteria so often is a diagnosis based on elimination of similar confusing conditions, one should naturally know his general medicine so thoroughly that obvious organic pathology may not be allowed to pass unnoticed. It is chiefly due to the careless diagnoses of "hysterical individual" that psychiatry still bears a position of second-hand importance to so many otherwise capable men. The necessity of a detailed physical, neurological and serological examination on every suspected individual if viewed in this light, will then be realized. One should be warned, however, that the search must not end on the finding of some tangible pathology. All the factors in the background of a peptic ulcer case must be thoroughly delved into before a successful therapeutic regime can be initiated. Of what avail, to put a patient on a Sippi diet with meticulous observation of the hourly gastric acidity, if the psychogenic factor, a complex over an unfaithful wife, is not cleared up. And yet this is the way medicine is practiced by far too many members of our honorable

profession.

The patient may be considered as an intricate mechanism, if you please, a conglomeration of organs and muscles not always directed in the most efficient manner by that enigma of scientists, the mind. The personality of that individual, his environment, his likes and dislikes and his ability to cope with disagreeable situations are all as essential to the doctor as is the x-ray report of a filling defect on the posterior wall of the stomach.

One should not come to the hasty conclusion, however, that even after such a careful scrutiny of all the findings a diagnosis can always be had. Numerous organic brain conditions exist, which in their incipency give no other signs of their presence than nervous and emotional irritability, weariness, or lethargy. The honest psychiatrist will not be ashamed to confess his uncertainty, and will then have to institute a policy of "watchful waiting" for further symptoms which will definitely establish the diagnosis.

Again, the menopause is not normally accompanied by psychic changes, and when such is the case, the psychogenic factor must be alleviated. As is well known, most women consider mental changes a necessary concomitant of the climacteric and will consequently seek no aid.

The possibility of malingering should always be considered in patients whose complaints are out of proportion to the findings, but the differentiation between conversion hysteria and wilful prevarication should be realized since it is as unfair to a hysterical patient to be branded a liar as it is unjust to

make a diagnosis of gonorrhea in a woman with a non-specific leucorrhoea.

PROGNOSIS

The prognosis depends upon the type of the individual, the external circumstances and the nature of the treatment. Generally, the prognosis is better in young individuals than in old and confirmed neurotics. Response to previous treatment is another factor to be considered before offering a definite prognosis. Partial cures and spontaneous remissions are common, temporary cures frequent, permanent cures rare, except in selected patients treated by psychoanalysis, or in gross conversion hysterias, such as occurred in the war, when the cause was removed and the method of therapy appropriate. Generally, once a hysteric, always a hysteric; but there is no danger to life, although fatalities have been reported in cases of hysteric anorexia and vomiting. (58)

TREATMENT

At the outset, it is essential to stress the role of prophylaxis in hysteria. Since the formative period of complexes begins in very early childhood the parents should attempt to appreciate the significance of their actions in the presence of a child individual who is much more alert and inquisitive than is commonly supposed.

Questions of sex are of paramount importance, and if the child is punished for asking about something which, if properly answered, would seem perfectly natural and would be accepted by him, he is bewildered. His curiosity, however, does not end

with punishment, but instead becomes intensified, so that he soon makes issues of all acts or things connected with the problem of sex. In the chapter on mechanisms of Hysteria, the manner in which the conflict then arises is explained.

Probably in no field of therapeutics is there as much necessity for individualization as in the treatment of hysteria. The average psychiatrist is fortified with many different tools of approach and it is his appreciation of that particular case which determines whether a simple suggestion course be followed, or a deeply involved and minutely detailed psycho-analysis be instituted. In many cases supportive treatment must be employed before the patient is physically able to undergo strenuous mental therapy. Sedatives and tonics, if given, should be only temporary and the patient must realize that they in themselves cannot cure.

Broadly, psychotherapy is the only successful treatment of hysteria. It has to do with any form of healing which has as its object treatment by mental influence. More specifically it can be divided into suggestion, aeration or ventilation, desensitization and re-education.

Dr. C. M. Campbell gives a brief, yet concise outline of treatment in which he considers most of the steps involved in psycho-analysis:

1. Establishment of rapport between the physician and the patient. This to be effective must be based on a certain amount of respect and confidence on the part of the patient.

The more completely the history, physical examination, mental examination, serological and blood tests are done, the more the patient feels he can depend on the results of those examinations. The physician must be quite frank in the matter. It is quite proper to tell the patient that before any final opinion can be given, it is necessary to complete the study of his case. This causes no difficulty, provided the physician has a definite investigative procedure outlined and starts the patient on it at once. Any patient is willing to wait for accurate information before the physician begins treatment.

2. Aeration or ventilation of the conflict material.

3. Desensitization, where in the patient is required to face frankly the traumatic and unpleasant experience of her past.

4. Re-education. Essentially, the development of clear insight on the part of the patient into the mechanism of her illness, the establishment of new habits of response and the formulation of an adequate industrial, social, recreational and activity program to insure further stabilization. (32)

Hypnosis.-Of great value in unearthing suppressed conflict material is the act of Hypnosis. It has not been used much in the last 25 years, probably because of the highly theatrical view placed upon it by the public, - as well as its indiscriminate use by faith healers and sooth-sayers. Its proper use, however, is a highly valuable tool in the kit of psycho-analysis. The greatest objection to its use is that it removes symptoms without reaching deeper lying factors. And yet this objection does not seem especially valid in view of what H. H. Hart has to say in regard to its use in hospital clinics.

"psycho-analysis is not only time consuming but purse consuming and in the present mode does not lend itself to the treatment of the vast and increasing numbers of neurotics who come to our hospital clinics today. It is in those patients who lack sufficient intellectual endowment to obtain the completer values of psychoanalysis and kindred approaches that the purpose of hypnosis as a useful auxiliary treatment is served.

Our psychiatric clinics are crowded with the dull normal and feeble-minded whose neuroses are not satisfactorily handled by persuasion, analysis or re-education, but in whom the never-ceasing fund of human suggestibility is present and is always apt to work as much against the physician as with him. Because we have not learned to make use of that suggestibility as cleverly as the quack, we are assisting the latter to thrive at our expense. Nevertheless, it is those very cases in which hypnotism along with re-education and a partially analytic procedure works best. (24)

Dr. B. Cohen elucidating on amnesia and psycho-analysis says:

"The therapeutic mechanism is said to be dissociation of the memory and surge of subconscious recollections breaking through the strata of upper unconsciousness becoming manifest with the oncoming hypnoid state. Buckley facilitated a recovery by a gradual process of re-education and reproduction of impressions recalled by friends and acquaintances of the patient. Pilgrem, in addition to hypnosis, frequently had the patient give the alphabet, halting at the letter which started his name. This

recollection was occasionally sufficient to evoke a train of associations.

Today a better method-psycho-analysis exists -

1. Dream analysis.
2. Free association - the patient looks abstractedly into the distance, paying no attention to the examiner and revealing every thought that enters her mind without effort at censorship.
3. Word association - The patient reclines in bed. The basic one hundred word stimulus group of Brill is employed, with relevant additions and substitutions suggested by the history. The time interval is noted by a stop watch, the record gap being measured from the moment of completion of the stimulation word phrase to the beginning of response.

According to Brill, prolonged interval before response, repetition of words of stimuli, and failure of reproduction are the features indicating a complex. Brill defines the word "complex" as a group of ideas of marked emotional accentuation which was split off from the consciousness and repressed into the unconsciousness. (42)

DREAMS

Perhaps of all the psycho-analytic procedures, dream analysis is the most debatable and yet the most productive method we have of bringing suppressed ideas into the open. It is well understood by very few and yet almost all psychiatrists resort to it with varying degrees of success.

Physicians of fifty years ago considered the dream a non-psychic act, as the manifestation of somatic irritations in the psychic life. Benz (1876) pronounced the dream "a bodily process, in all cases useless, in many cases actually pathological, above which the world-soul and immortality are raised as high as the blue ether over the weed-grown sands of the lowest plain".

The dream is the sleep disturbing remnant of waking-life and is due to stimuli which are working on the psyche and have not been satisfactorily reacted to by the mind in the awakened state. In interpreting dreams, never omit any idea from their account, even if one of following objections should arise; that is, if it should seem too unimportant, absurd, too irrelevant or too embarrassing to relate.

The task of interpreting dreams is carried on against a certain resistance which manifests itself by these critical objections. These ideas which we are so anxious to suppress, prove without exception to be the most important, the most decisive, in the search for the unconscious.

A displacement of emphasis is a favorite device of the

dream distortion and gives the dream that strangeness which makes the dreamer himself unwilling to recognize it as his own production. The distortion of dreams is in a degree proportional with the prudishness of the dream.

Symbolism is perhaps the most noteworthy chapter of dream study. The idea of the symbol cannot be sharply delimited at all times, it mingles with the substitution, dramatization, etc. even approaching the allusion.

Wish fulfillment is another interesting phase of dream interpretation. Sometimes the wish is so evident that the dreamer needs no explanation. At other times, it is discovered only after detailed inquiry into the patient's personality, with due consideration of symbolism and dream distortion. (44)

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